

Health Insurance Options

sb/a freedom & Ep6ix MVP health plans

Base Monthly Billable Rates for start MVP Plan Summary Plan of Benefits	Bronze Plus	Silver	HBA ENHANCED MVP GOLD
PPO Network	First Health	First Health	First Health
Deductible	None	None	None
Annual Out-of-Pocket Maximum	*Deductible may apply to Brand Rx \$8,000 / \$16,000	*Deductible may apply to Brand Rx \$7,000 / \$14,000	*Deductible may apply to Brand Rx \$6,000 / \$12,000
ACA Preventive & Wellness	Covered 100%	Covered 100%	Covered 100%
Telemedicine	\$0 Copay	\$0 Copay	\$0 Copay
Primary Care (Wellness)	\$0 Copay	\$0 Copay	\$0 Copay
Primary Care (Sick Visit)	\$50 Copay	\$35 Copay	\$25 Copay
Specialist (Includes Outpatient Behavior Health)	4 visits per year \$75 Copay 4 visits per year	6 visits per year \$50 Copay 6 visits per year	8 visits per year \$35 Copay 8 visits per year
Urgent Care	\$75 Copay 2 visits per year	\$50 Copay 3 visits per year	\$35 Copay 4 visits per year
Physical & Occupational Therapy	\$75 Copay 4 visits per year	\$50 Copay 6 visits per year	\$35 Copay 8 visits per year
Lab & X-Ray (Non-Hospital Based)	\$75 Copay 3 visits per year	\$50 Copay 4 visits per year	\$35 Copay 5 visits per year
Complex Medical Imaging (MRI/CT Scan)	\$750 Copay 1 visit per year	\$500 Copay 2 visits per year	\$375 Copay 3 visits per year
Surgery - Outpatient	\$750 Copay 1 per year	\$500 Copay 2 per year	\$375 Copay 3 per year
Surgery - Inpatient	\$750 Copay 2 per year	\$500 Copay 2 per year	\$375 Copay 3 per year
Emergency Room	\$750 Copay 1 visit per year	\$500 Copay 1 visit per year	\$375 Copay 2 visits per year
Inpatient - Hospitalization & ICU	\$1,500 Copay per Admission 5 Days Maximum per year	\$1,000 Copay per Admission 7 Days Maximum per year	\$750 Copay per Admission 10 Days Maximum per year
Maternity Global Services Facility and Professional Fees	\$3,400 Copay Childbirth / Delivery	\$2,300 Copay Childbirth / Delivery	\$1,700 Copay Childbirth / Delivery
Generic Rx - Tier 1 (Preventive)	\$0 Copay	\$0 Copay	\$0 Copay
Generic RX - Tier 2 (Non-Preventative)	40% Coinsurance	30% Coinsurance	20% Coinsurance
Brand RX: Tier 3 (Preferred)	\$500 Deductible	\$250 Deductible	No Deductible
Brand RX - Tier 4 (Non-Pref)	40% Coinsurance \$500 Benefit Cap on Eligible Prescription per Month	30% Coinsurance \$500 Benefit Cap on Eligible Prescription per Month	20% Coinsurance \$500 Benefit Cap on Eligible Prescription per Month
Specialty Rx:	Not Covered	Not Covered	Not Covered
Employee Only	\$491.92	\$580.07	\$681.18
Employee + Spouse	\$769.47	\$927.93	\$1,111.28
Employee + Child(ren)	\$730.34	\$877.43	\$1,048.06
Employee + Family	\$983.79	\$1,188.26	\$1,411.20